Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

http://www.dmas.state.va.us

MEDICAID MEMO

TO: All Providers of Pre-Admission Screening Services Participating in the Virginia Medical Assistance Program and Managed Care Organizations

FROM: Cynthia B. Jones, Director
Department of Medical Assistance Services (DMAS)

MEMO: Special

DATE: 10/25/2013

SUBJECT: Pre-Admission Screening Guidance

The purpose of this memorandum is to provide clarification for pre-admission screening teams and hospital screeners on the pre-admission screening process. This information is to be used as supplemental information for the existing pre-admission screening process. This guidance does not replace the requirements for pre-admission screening.

On October 3, 2012, the Department of Medical Assistance Services (DMAS) issued guidelines to assist pre-admission screening teams with the process of screening children, including children with developmental (DD) and intellectual disabilities (ID). The information provided were guidelines for screening teams to assist in screening individuals with ID/DD to receive services, under the Medicaid Elderly or Disabled with Consumer Directed (EDCD) Waiver.

Outlined below are a series of clarifications which DMAS is sharing with pre-admission screening teams in an effort to assist with concerns or questions teams may have about the pre-admission screening process.

Pre-Admission Screening Requirements:

1) Pre-admission screening teams should complete requests for pre-admission screening for services in a timely manner to assure timely delivery of services to individuals seeking nursing facility placement or services under a home and community based waiver program.
2) Being at risk for institutionalization does not mean that an individual has to be placed into an institution or nursing facility prior to receiving waiver services. It means that without waiver services the individual would require admission to a facility.
3) The following information appears in 12VAC30-60-312: Federal regulations which govern Medicaid-funded home and community-based services require that services only be offered to individuals who would otherwise require institutional placement in the absence of home- and community-based services. (The determination that an individual would otherwise require placement in a nursing facility is based upon a finding that the individual's current condition and available support are insufficient to enable the individual to remain in the home and thus the individual is at risk of institutionalization if community-based care is not authorized.) The determination of the individual's risk of nursing facility placement shall be documented either on the state-designated pre-admission screening assessment or in a separate attachment for every individual authorized to receive community-based waiver services. To authorize community-based waiver services, the screening team must document that the individual is at risk of nursing facility placement by finding that one of the following conditions is met:

    1. Application for the individual to a nursing facility has been made and accepted;

2. The individual has been cared for in the home prior to the assessment and evidence is available demonstrating deterioration in the individual's health care condition or a change in available support preventing former care arrangements from meeting the individual's need. Examples of such evidence may be, but shall not necessarily be limited to:
    a. Recent hospitalizations;
    b. Attending physician documentation; or
    c. Reported findings from medical or social service agencies.
3. There has been no change in condition or available support but evidence is available that demonstrates the individual's functional, medical and nursing needs are not being met. Examples of such evidence may be, but shall not necessarily be limited to:
    a. Recent hospitalizations;
    b. Attending physician documentation; or
    c. Reported findings from medical or social service agencies.

4) Hospital pre-admission screenings must be completed prior to hospital discharge. This includes all required forms (UAI, DMAS-96, DMAS-95 MI/ID/RC – for nursing facility placements only, and the DMAS-97). No pre-admission screening documents may be completed post discharge for any individual.
5) Hospitals may not refuse to perform pre-admission screenings for individuals being identified as needing long term care services prior to discharge. As part of proper discharge planning, the hospital **is required** to complete the pre-admission screening so that the individual may access services upon discharge from the hospital.
6) It is not appropriate to instruct individuals or their families or advocates to admit someone to the emergency room only for the specific purpose of facilitating the hospital to complete the pre-admission screening process. However, if the emergency room admission is appropriate, and it is determined that long term care services are necessary post discharge, the pre-admission screening may be completed by emergency room staff.
7) Children are considered a household of one for the purposes of Medicaid Waiver financial determinations. **Screenings must be completed regardless of whether or not an individual has made application for Medicaid coverage for financial reasons.** There are no requirements that an individual must be determined eligible financially before they can request a pre-admission screening.
8) **It is not appropriate to instruct individuals, their families, or advocates to apply for financial eligibility coverage for Medicaid as a requirement for pre-admission screening.** Individuals are not required to have Medicaid financial coverage determined prior to the pre-admission screening process being initiated or completed.
9) Pre-admission screening teams are not required to update pre-admission screening documents for individuals if the individual needs an increase in hours. It is the responsibility of the provider or the individual's service facilitator to update the plan of care and other documents and submit them to DMAS' service authorization contractor for review and processing.
10) The DMAS-95 Addendum is a form used for individuals who choose to consumer-direct and is related to the EDCD Waiver. This must be completed if at the time of the screening the individual indicates they wish to receive their services through the consumer directed service delivery model. This only applies to those individuals receiving services through consumer direction. The DMAS-95 Addendum is not required if a family member or other person is going to be the employer of record.

Pre-Admission Screening EDCD Eligibility Requirements:

11) An individual, who meets the functional criteria for EDCD Waiver, has medical/nursing needs, is at risk for institutionalization within 30 days in the absence of waiver services and has a diagnosis of autism or autism related condition may qualify for the EDCD Waiver.

12) For EDCD Waiver screening and eligibility, evidence that the individual is at risk of a nursing facility placement can include, but is not limited to: Recent hospitalizations, attending physician documentation or reported findings from medical or social services agencies.
13) Individuals with developmental disabilities or intellectual disabilities who have behavioral needs may be eligible for the EDCD waiver if they meet all other EDCD Waiver criteria.
14) Individuals receiving therapeutic foster care can receive services through the EDCD Waiver if they meet the criteria for the waiver and they do not duplicate any services offered under the EDCD Waiver.
15) It is not appropriate to instruct individuals, their families or advocates to apply for a nursing facility placement as a condition of being screened for the EDCD Waiver. In addition, it not appropriate to tell people they will not be found eligible for the EDCD Waiver unless they have applied for or been admitted to a nursing home.

Level II Screenings for Mental Illness, Intellectual/Developmental Disabilities or Related Conditions (applies only to nursing facility admissions)

16) The DMAS-95 Level I for MI/ID/RC is a federal requirement for all NF admissions in which an individual has a mental illness, intellectual disability or related condition. If an individual is identified as having any of these diagnoses, the Level II portion must also be completed by the contractor (Ascend Management Innovations) prior to NF admission. However, this is not required for EDCD Waiver enrollment.
17) The contact information for Ascend Management Innovations is: Phone: 877.431.1388 extension 3206; Fax: 877.431.9568; website: www.ascendami.com

Additional information about the pre-admission screening process may be found in the Pre-Admission Screening Provider Manual which is available on the DMAS web portal (www.virginiamedicaid.dmas.virginia.gov).

Screening teams may always submit questions through the DMAS info e-mail address. The e-mail address is: dmasinfo@dmas.virginia.gov. Screening teams may also contact the Provider HelpLine for questions related to the pre-admission screening process. See information below for contacting the Provider HelpLine.

When there is a refusal to do a screening or the prescreening results in the screening team deciding not to meet with the individual to do a full screening, notice to the individual should be provided. This notice is required to be in writing and include six items including the reasons the screening is being denied (Please reference 12VAC30-110-70 for additional information regarding written notices).

VIRGINIA MEDICAID WEB PORTAL

DMAS offers a web-based Internet option to access information regarding Medicaid or FAMIS member eligibility, claims status, check status, service limits, service authorizations, and electronic copies of remittance advices. Providers must register through the Virginia Medicaid Web Portal in order to access this information. The Virginia Medicaid Web Portal can be accessed by going to: www.virginiamedicaid.dmas.virginia.gov. If you have any questions regarding the Virginia Medicaid Web Portal, please contact the Xerox State Healthcare Web Portal Support Helpdesk, toll free, at 1-866-352-0496 from 8:00 a.m. to 5:00 p.m. Monday through Friday, except holidays. The MediCall audio response system provides similar information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider. Providers may also access service authorization information including status via KePRO's Provider Portal at http://dmas.kepro.com.

"HELPLINE"

The "HELPLINE" is available to answer questions Monday through Friday from 8:00 a.m. to 5:00 p.m., except on holidays. The "HELPLINE" numbers are:

1-804-786-6273 Richmond area and out-of-state long distance
1-800-552-8627 All other areas (in-state, toll-free long distance)

Please remember that the "HELPLINE" is for provider use only. Please have your Medicaid Provider Identification Number available when you call.